GARTH L. SPLINTER, M.D., M.B.A.
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

October **3,** 1995

Lu Zawistowich, Sc.D.
Office of Demonstration and Evaluation
6325 Security Boulevard
Baltimore, MD 21207

Dear Dr. Zawistowich,

Enclosed, please find the Protocol for Oklahoma's 1115(a) demonstration proposal. It is complete except for the inclusion of Section 11 which will address services under the program for American Indians. **As** we agreed, that portion of the Protocol will be provided to you by October 31, 1995.

If you have any questions or concerns, please don't hesitate to contact me or Leigh Brown at (405) 530-3439. We look forward to working with you on the project.

Sincerely,

/s/

Garth L. Splinter, M.D., M.B.A.
Chief Executive Officer

STATE OF OKLAHOMA

Oklahoma Health Care Authority

1115(a) Demonstration Protocol

September 30,1995

STATE OF OKLAHOMA

Health Care Authority

§1115(a) Demonstration Protocol

Amended February 26,1997

• 4545 North Lincoln Boulevard •
Suite 124
Oklahoma City, OK 73105-3413

Catalog of Page Substitutions
§1115(a) Demonstration Protocol

Oklahoma Health Care **Authority**
February 26,1997

GENERAL NOTE:

The general format utilized to indicate changes is to and underline new language. The only exception to this format *can* be found within Attachment 18. This Attachment is entirely new, and the material presented therein consists of pre-printed instructions and/or forms, making "underlining" an impossibility.

Pages that contain changes will have a "footer" at the bortom left hand corner of the page indicating that the page was either "...Amended..."or "...Added..."as of February, **1997.** In addition, if a particular page within the body of the Protocol (not applicable to the Attachments) was added due to the addition of language (i.e. pp. 95.1 or 129), the page numbers will also be underlined.

PAGE SUBSTITUTIONS (INCLUDING BRIEF DESCRIPTION):

Old Page (to be Deleted)	New Page (to be Added)	Brief Description of the Change(s)
Cover Page	Cover Page	Shows date of Protocol Amendment.
1 (Table of Contents)	1 (Table of Contents)	Shows Chapters and/or Attachments that have been added to the Protocol with this Amendment.
60	60, 60.1	References Chapter 16 and Year III SMVSED Voluntary Enrollment.
64	**64**	References change in lock-in provisions for members in rural PCCM program. Also references State's intention to lock-in rural members into PCCM/network in the future.
95	95, 95.1	Separates Extended Family Planning and SMI/SED enrollment planning components. Defines handling of SMUSED enrollments in Years I, II, **and** 111.
96	96	Shows deletion of language caused by changes to pp. 95 and 95.1.
None	129,130,131	New Chapter 16.
None	Attachment # 18	Addition of SMI/SED Application and Determination Procedures.
None	Attachment # 19	Detail of Behavioral Health, Alternative, and SMVSED Benefit Packages for Urban ***SoonerCare*** for Year 111.

TABLE OF CONTENTS

Attachments

OKLAHOMA HEALTH CARE AUTHORITY
1115(A) DEMONSTRATION
PROTOCOL

PREFACE

This document contains Oklahoma's operational protocol for implementation and administration of the *SoonerCare* demonstration pursuant to terms and conditions of the State's 1115(a) waiver.

Because Oklahoma initially will be operating fully- and partially-capitated systems in different parts of the State, many sections of the protocol address full and partial capitation policies separately. In discussing the fully capitated system, the terms "health plan" and "managed care organization" (MCO) are used interchangeably. The fully capitated portion of the State also is sometimes referred to as the "urban health plan/Rural Partner" region(s), in recognition that MCO service areas will be redrawn next year to encompass surrounding rural counties, thereby permitting contracted plans to qualify for Rural Partner status (this planned service area expansion is outlined in detail in section 1 of the protocol).

In discussing the partially-capitated system, most references are to the primary care case management model that will be implemented in 1996. However, a number of sections also discuss the Outpatient Network and other demonstration models intended for implementation in out-years of the waiver.

1, ORGANIZATIONAL AND STRUCTURAL CONFIGURATION OF THE *SOONERCARE* DEMONSTRATION

Introduction

This section of Oklahoma's operational protocol describes the different managed care organizations and structures that will be used to enroll and serve most of the State's non-institutionalized Title XIX population. It begins with a brief overview of the State's general approach to implementing managed care, followed by more detailed descriptions of the urban health plan/"Rural Partner" model and the rural partial-capitation program. It concludes with a discussion of the State's approach to expanding managed care under both models to incorporate Aged, Blind, and Disabled beneficiaries.

Overview

Oklahoma's 1115(a) demonstration will build on the managed care program implemented in August, 1995 in the State's three major metropolitan areas under a 1915(b) waiver, submitted while the State awaited approval of it's 1115(a) application. Under the demonstration, managed care will be extended into all areas of the State, beginning during State Fiscal Years (SFYs) 1995 and 1996 with implementation of a system of primary care case management in areas of the State not served by health plans and expansion of the current health plan service areas into rural counties not yet served by plans. Thereafter, throughout the remaining period of the demonstration, fully integrated managed care networks and other innovative managed care models will be introduced into rural areas of the State initially served by the partial capitation model.

Urban Health Plans/Rural Partners

In August 1995, Oklahoma implemented a mandatory managed care program for AFDC and AFDC-related beneficiaries in three metropolitan areas: Oklahoma City, Tulsa, and Lawton (Comanche County). These communities were chosen because they met three criteria considered essential for program success: 1) they had a sufficient Medicaid population base to support multiple health plans (also referred to as Managed Care Organizations, or MCOs); **2)** they had fully integrated networks in operation or in the process of being formed; and **3)** they serve as referral centers for surrounding rural communities, thereby offering the potential for plans formed within them to affiliate formally with rural providers over the next several years.

The State ultimately contracted with four MCOs in Oklahoma City (BlueLincs, Community Care, Foundation Health, and Heartland Health Plan (the University of Oklahoma's MCO)); three in Tulsa (BlueLincs, Community Care, and Foundation Health), and three in Comanche County (BlueLincs, Foundation Health, and PacifiCare). Contracts were signed for the period August 1, 1995 - June **30,** 1996.

When the 1115(a) demonstration is implemented in January, 1996, health plans in the three metropolitan areas currently operating under the State's 1915(b) waiver will continue to operate with contracts executed under the 1915(b) waiver until the next contract period begins on July 1, 1996. Accordingly, the plans will not be permitted to immediately take advantage of the following 1115(a) waiver provisions: a) six months of guaranteed eligibility; b) 12-month lock-in of client enrollment; c) permanent waiver of the 75/25 membership composition rule; and, **4)** lock-in to provider network for adults receiving family planning services.

Beginning July 1, 1996 (SFY 1996), each of the three existing health plan service areas will be expanded significantly to encompass contiguous counties with larger, more sparsely-populated areas that are currently served predominately through rural provider systems. Specifically:

- In the Oklahoma City metropolitan area, the Authority is considering expansion of the health plan service area to include all of Cleveland County (currently only the more densely-populated Norman and Moore areas are included), all of Canadian County (currently only the small towns of Yukon and Mustang are included), Pottawatomie County and Logan County. These counties have been selected because: 1) Cleveland and Canadian Counties already have about 40% of their AFDC populations enrolled in health plans (these are persons living in portions of the counties already included in the Oklahoma City service area; and ***2)*** the local hospitals in these counties have expressed a desire participate in the managed care program through inclusion in MCO networks.

- In the Tulsa metropolitan area, the Authority is considering expansion of the health plan service area to include all of Rogers, Creek and Wagner Counties. These counties include the town of Claremore in which a community hospital and IHS hospital serving the Cherokee and Creek Nations are located.

- In the Comanche County area, the Authority is considering expansion of the health plan service to include Kiowa County and Jackson County. Altus Air Force Base is located in the Jackson County town of Altus. Currently Foundation Health has a contract to provide CHAMPUS services at the Air Force Base and so is in the process of establishing a significant provider network in the community. BlueLincs and PacificCare also have recently started to serve businesses in the area and are expanding their networks accordingly. Kiowa County, located between Jackson and Comanche County, is very sparsely-populated, but could benefit significantly from being able to access integrated services from the other counties.

Under the terms of Oklahoma's waiver, one of the methods by which MCOs can qualify for Rural Partner status is by expanding their networks into rural areas and agreeing to enroll at least 500 rural beneficiaries, or a number equal to 10% of their urban enrollment, whichever is greater. The new service area boundaries will in fact be drawn in such a way as to ensure that a significant number of rural beneficiaries are added to each service

area, thereby allowing participating MCOs to qualify for Rural Partner status upon receiving a contract award.

Attachment 1 to the protocol shows the current metropolitan service area boundaries and the expanded boundaries as presently envisioned. The final boundaries for these three expanded service areas will be defined in the State's upcoming health plan Request for Proposals, as discussed below. Attachment 2 identifies the number of Title XIX eligibles currently served by MCOs in each of the three catchment areas and projects the number of eligibles which will be added to each catchment area with the proposed rural expansion. It also specifies the percentage increase in capacity that will be achieved through the expansion.

In addition to qualifying MCOs as Rural Partners through this method, the State also will show preference in its contract awards to plans that increase their rural outreach in one or more of the following ways:

- Establishing and operating a telemedicine consultation/referral system that includes at least twenty-five rural Oklahoma hospitals; or

- At the request of a tribal health program, significantly assisting in the development, contract management, or tertiary referral/specialist component of a tribal health program serving Title XIX recipients; or

- Proposing an alternative method to the State for significantly increasing access to managed health care among rural *SoonerCare* beneficiaries/providers, subject to the State's and HCFA's approval.

During the SFY 1997 contracting period when the State begins implementation of alternative rural models (as discussed below), MCOs will receive additional bidder points to the extent they are willing to provide two additional functions:

- Agreeing to provide the tertiary/specialist referral component for one or more rural Outpatient Networks/health plans, again subject to the same capacity test as described above; or

- Agreeing to serve as a contract manager for a capitated rural provider network (performing plan administrative functions such as claims processing and encounter reporting), subject to the same capacity test as described above.

In order to prepare all health plans for the increased outreach that will be required into rural areas of the State under the "Rural Partner" provisions, the State will work with current health plans, as well as health plans which have expressed an interest in participating with the program in the next contract year, to develop sufficient rural outreach to qualify as "Rural Partners" when the new contracts are executed. This will be accomplished during monthly medical director meetings which are conducted with all

current contracting health plan medical directors, through monthly operational status meetings for health plan administrators conducted by the Managed Care Division and through technical assistance conferences for all health plans.

Competitive bids will be required for all MCOs serving the expanded service areas. The Authority's Business and Contracts Manager, in collaboration with the Agency's Purchasing Manager, will coordinate all activities related to the procurement of health plans, including preparation and submission of the health plan RFP, technical assistance for health plans in the contracting process, release and processing of the RFPs, including on-site reviews, and bid awards.

In December 1995, the State will submit its RFP for the three expanded service areas for the next contract year (July 1, 1996 - June 30, 1997) to HCFA for the Agency's review and approval. The RFP will be released to health plans by February 1, 1996. Contract awards will be made in the Spring and will confer 1115(a) status on all selected MCOs, effective July 1, 1996. MCO contracts will contain the various 1115(a) provisions previously noted.

In May, 1996 the State will begin health plan open enrollment activities by distributing enrollment information, including provider directories, to all Title XIX beneficiaries who are members of MCOs serving the three metropolitan areas at that time, as well as to eligible beneficiaries from contiguous counties comprising the expanded area. Clients who desire additional information or clarification regarding the materials will be instructed to call the State's toll-free telephone enrollment agent, "Benova", or the Authority's Enrollment Unit.

Clients who have previously been enrolled in MCOs will have the opportunity to change plans by either 1) executing a plan change through Benova; or, 2) completing and returning a stamped, addressed enrollment card to the Oklahoma Health Care Authority. Clients who do not select a new plan will remain with their current plan.

Clients residing in the newly-integrated contiguous counties also will be able to enroll in a health plan using either of the two mechanisms described above. Those who do not select a plan will be assigned to one by the State, using an assignment algorithm developed for the program and previously shared with HCFA. In addition, as new applicants seek certification for the Title XIX program, they will be given information during the face-to-face application interview with their DHS case worker regarding the *SoonerCare* program. They then have the opportunity to select a health plan during their interview or afterward through either of the two methods described above. The eligibility-determination process, as well as the State's enrollment process, are described in greater detail in Sections 6 and 8 of the protocol.

Rural Partial Capitation Model

When the ***SoonerCare*** 1115(a) demonstration is implemented on January 1, 1996, the State will immediately begin implementation of its rural managed care system through establishment of a system of Primary Care Case Management (PCCM) in areas not targeted for inclusion in the expanded MCO regions. While clients and in the three expanded health plan service areas will not be covered by the terms of the 1115(a) demonstration until new health plan contracts are executed, effective July 1, 1996, ***SoonerCare*** enrollees who reside outside the three expanded service areas will immediately be covered by all the waivers requested in Oklahoma's Section 1115 proposal, upon enrollment with a PCCM. This includes six months of guaranteed eligibility and a twelve-month locked-in enrollment to their managed care provider.

Under the system which the State currently intends to establish, only one primary care model will be used in the rural areas, rather than the Primary Care I (PCI) and Primary Care II (PCII) models that were proposed in the initial 1115(a) waiver application'. In the system as now configured, primary care case managers will be capitated for primary care services and a basic package of ancillary services, including a limited package of laboratory procedure. In addition, they will be responsible for referrals for most specialty services, excluding eye and dental care, obstetrical services, behavioral health services and family planning services for adolescents.

The PCCM program will be open to General/Family Practitioners, Pediatricians, and Internists, along with physicians from other specialities who receive special certification to participate. A letter and application form have been developed through which physicians outside the four primary care areas may petition the Authority for inclusion as primary care case managers in the ***Soonercare*** program. (See Attachment 3 for a copy of the letter. It will be distributed to all non-primary care rural physicians in the State. Agency regulations specify that factors which may be considered in determining whether these physicians may participate as primary care physicians include: 1) the percentage of the physician's practice engaged in primary care; 2) the physician's historical commitment to serving Medicaid clients; 3) the number of primary care providers located within the geographic area in which the physician's practice is located in relationship to the number of Title XIX recipients in the area; and, 4) the physician's education and training.)

Rural** Pilot **Counties

The State will begin implementation of its PCCM system through establishment of the program in three contiguous pilot counties -- Hughes, Seminole and Okfuskee counties (see Attachment 4 for a map of these counties). This will allow the program to ensure that enrollment and information systems are operating at optimal efficiency when the full

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'Based on discussions with providers throughout the State, it was determined that a single PCCM capitated benefit package could be constructed that would accommodate most physicians, thereby reducing the program's complexity.

system is implemented approximately 90 days later. It will also facilitate the identification and resolution of potential problems prior to full enrollment.

These counties, which currently contain a total of 7,454 AFDC-eligible clients, were selected based on a number of factors, including the State's ability to work with local communities in program development. They are all located within the Department of Human Services Region 3, a region in which the supervisor and county workers have expressed interest in, and knowledge of, managed care delivery. In addition the counties were found to have a sufficient provider base to support mandatory enrollment of all eligible clients into a PCCM system. Specifically, they contain:

- Twenty-five (25) primary care providers, 18 of whom currently participate in Medicaid, which equates to a member-to-provider ratio of 276-to-1 (414-to-1 if limited to currently participating providers only)

- Four rural health clinics and one federally qualified health center, which has expressed a strong interest in participating in the program

- Two mobile clinics that deliver services throughout the counties

- In addition, two American Indian tribes, the Muskogee Creek and Seminole tribes, have health facilities located within these counties. The Creek Nation operates a hospital in Okfuskee County, in the town of Okemah. Their presence will enable the State to develop mechanisms with the tribes for client outreach and integration of tribal providers which should prove valuable as the PCCM program is implemented in other areas of Oklahoma with significant tribal health programs.

During October and November, 1995, the Managed Care Division's Managed Care Coordinators and persons from the Enrollment Unit will work intensively with other agency staff to educate providers and county office workers in the pilot counties about the program. Meetings will be set up through DHS, county medical societies, local hospitals and tribal facilities. In addition, staff will contact individual providers to ensure that they understand the system and to resolve any questions or issues they may have. Providers having questions or concerns also will be able to contact the Agency's Provider Relations Division through a Statewide toll-free telephone number.

The Health Care Authority's Business and Contracts Manager will be responsible for coordinating preparation, review and mailing of physician contracts for the rural PCCM system. She will also be responsible for all interactions with **HCFA** regarding the contracts. The model contract and benefits package that will be used in the State's PCCM system are currently being reviewed by providers throughout the State, including physicians from the four primary care specialty areas, the State's two colleges of medicine, hospital providers from both urban and rural areas and the director of the

University of Oklahoma Nurse Practitioner Program. The model contract and benefits package will be submitted to HCFA for its review under separate cover in early October.

PCCM contracts will be mailed to primary care providers in the pilot area in mid-October. The contracts will contain a return due date of November 15, 1995. Once all signed contracts have been returned, the State will assemble provider directories and enrollment packets for mail-out by December 15, 1995.

The provider directories will be developed with all providers listed by county. A computer-mapping program will be used to help identify proximity of providers to beneficiaries to ensure that all clients have access to clients within 45 minutes/45 miles of primary care providers under contract with the program. Whenever possible, clients will be encouraged to select a provider within 30 minutes/30 miles. Clients who do not select a primary care provider will be auto-assigned by county.

Enrollment materials, including provider directories, will be mailed to Title XIX AFDC recipients in the pilot counties on January 2, 1996. During February, 1996, clients who select a PCCM provider will be enrolled with the provider, while clients who do not select a provider will be randomly assigned to one, based on provider capacity and location. Enrollment will be effective for service delivery beginning March 1, 1996.

Statewide PCCM Implementation

Title XIX recipients will be enrolled in the remainder of the State during an open enrollment period in April, 1996, with service delivery beginning June 1, 1996. PCCM contracts will be mailed to primary care providers on January 2, 1996 with a return due date of February 15,1996. The signed and returned contracts will be processed and provider directories and enrollment packets printed by March 31, 1996.

Enrollment packets and provider directories will be mailed to elgible Title XIX clients on April 1,1996. During February, March and April, intensive outreach will be conducted with DHS county offices, primary care providers and tribal health programs who will participate in the program. The process of enrolling or assigning clients to providers will be completed during May and primary care case management under ***SoonerCare*** outside of the pilot counties will begin on June 1, 1996.

Other Rural Models

Beginning in July, 1997, models other than primary care case management will be instituted within the rural areas of the State, through continued expansion of the MCO service areas and introduction of Outpatient Networks. In addition, because of significant interest from a number of rural communities with stable health provider systems, the State is currently exploring establishment of at least two fully-capitated rural pilot projects to be operated in counties not included in the standard MCO service areas.

Outpatient Network Model

Just as it is the State's initial short-term goal to implement the PCCM model Statewide, it is the State's long-term goal to encourage establishment of Outpatient Networks, wherever feasible, as a first step to the introduction of fully-integrated networks. The Outpatient Network is a sophisticated model which would incorporate a capitation payment for most or all outpatient services. It would most likely be utilized by a provider group such as a physician-hospital organization (PHO) because it will require the capitated entity to assume a significant degree of risk. In addition, it would require sufficient resources as well as an advanced level of medical management expertise to initiate and maintain it.

The Outpatient Network would serve as a transitional step for organizations committed to forming MCOs but requiring time to build sufficient provider networks or gain additional managed care expertise before assuming risk for all services. Policies for Outpatient Networks with respect to covered services will be identical to those for MCOs, with the exclusion of capitation for inpatient hospital care. The Outpatient Network model will require a sufficient Medicaid population to adequately support enhanced levels of capitated services where physicians, hospitals and other providers are willing to make a contractual commitment to this arrangement.

The Oklahoma State Department of Health has developed rules and procedures for licensure of Outpatient Networks as pre-paid health plans. Outpatient Networks will be required to meet both net worth and reserve levels, as established by Health Department regulations, or could request waiver of these requirements at the discretion of the agency. Before the State would consider a proposal for an Outpatient Network, the applicant would have to submit documentation of licensure as a pre-paid health plan.

The Managed Care Division will work with provider groups interested in the development of this model and will consider proposals for one or more Outpatient Networks. However, service delivery for this model will not begin prior to June 1,1997. This delay will permit the State to conduct initial implementation of the PCCM model as the only rural model and provide potential Networks with sufficient time to develop provider partnerships and to apply and receive licensure.

The capitation package and capitation rates for the Outpatient Network model have not been absolutely defined but would most likely include primary care and specialist physician services, case management services, immunizations, family planning services, laboratory and x-ray services, EPSDT services, ambulatory services including ambulatory surgery, prenatal and delivery services, podiatry services, optometry services, chiropractic services, outpatient hospital clinic services, emergency room services, physical therapy, services for speech, hearing, and language disorders, prescription drugs, vision services, diagnostic, screening, preventive and rehabilitative services, emergency transportation.

The Managed Care Division Financial Manager will closely monitor all financial aspects of this model from the capitation arrangement to regularly scheduled financial review to ensure solvency. It is unlikely that Outpatient Networks would initially have the financial expertise necessary to formulate and submit actuarially sound bids, therefore the State would set the initial capitation rates for this model based upon historical data. If, in later years, the State determines that these Outpatient Networks are equipped to formulate bids, the State will move to a competitive procurement for those organizations consistent with the approach used in urban areas.

***Pilot** Rural Networks Demonstration Projects*

As noted above, the State is currently exploring establishment of at least two fully-capitated rural pilot projects to be operated in counties not included in the standard MCO service areas. Under these pilot projects, if strong support existed from local communities, sub-capitated, rural networks would be developed in which all inpatient and outpatient primary care services and specialty services available within the county would be included. Eligible communities would be required to demonstrate that they are able to assume the risk associated with all inpatient and outpatient services. Networks would be permitted only in cases where the county had at least one hospital which was financially solvent and, at a minimum, the community had sufficient primary care capabilities, including sufficient primary care providers willing to participate in the program, to deliver a full range of inpatient and outpatient primary care services to all eligible Title XIX clients in the county.

Networks could be administered by local hospitals with qualified personnel, by contracted management companies, or by fully-capitated HMOs acting as Rural Partners. However, in order to be considered for participation, networks would be required to link with fully-integrated health plans for all tertiary services. To accomplish this, the State would release an RFP to all licensed HMOs and public managed care plans in Oklahoma seeking plans interested in providing and risk for tertiary services beyond the scope of the rural network. These plans would also have to agree to return clients to local communities when tertiary service delivery was completed.

Approval of contract bids would be contingent upon evaluation of fiscal solvency and administrative capabilities of both the rural network and the health plan, evaluations of contracts between the two entities, and documentation of operational readiness of both the rural community network and the tertiary network. Operational readiness would include the ability of both the rural network and the health plan to deliver the full range of medically-necessary services to all Title XIX-eligible clients in the county. Consistent with the process for MCO RFPs and contracts, the State would submit the RFPs and contracts for these rural networks to HCFA for review and approval prior to release or execution.

Aged, Blind and Disabled Populations

The State intends to enroll the non-institutionalized ABD populations in the expanded metropolitan health plan areas for the contract year beginning July 1, 1996. **ABD** clients will be enrolled with PCCMs in rural Oklahoma by the end of 1996.

Prior to enrollment of ABD clients, the State will undertake significant efforts to ensure MCOs and PCCM physicians are prepared to serve this population and that clients are well-informed about the managed care program and their options within it. In the case of MCOs, the State's RFP for SFY 1997 will contain standards specific to the **ABD** population, including with respect to provider networks, eligible PCP specialties, outreach and education, quality assurance and case management activities, and member services. The State and its actuaries also will be developing capitation rate ranges for ABD clients that recognize the significantly high cost profile of this population versus AFDC beneficiaries.

In rural areas, the State will begin with an assessment of the initial PCCM network on a county-by-county basis to determine its adequacy to enroll and serve ABD clients (note: the initial contract executed with PCCMs serving AFDC clients will include a provision for adding ABD beneficiaries at the time these persons are enrolled in managed care). If necessary, the State will conduct a second round of contracting with rural providers, including sub-specialists, to ensure satisfactory capacity exists before enrollment begins.

The State will conduct significant outreach and education of clients in both urban and rural areas prior to enrolling ABD clients. All eligible clients in the three urban service areas will receive information about the program through the methods described in the "Urban Health Plans/Rural Partners" section above. Clients in the remainder of the State will be contacted through the methods described above for rural AFDC clients, although the outreach will take place in the Fall of 1996. This "standard" outreach will be supplemented through creation of special videotapes for ABD clients to be played in DHS county offices and the development of other outreach/education initiatives in collaboration with advocacy groups for the elderly and disabled and other state agencies serving these *two* groups.

Significant outreach will be conducted by the Managed Care Division to educate clients about the program and to assist them in enrollment. The State'stoll-free telephone enrollment agent will also be available to provide information and assistance to clients. **A** special videotape for DHS county offices will be developed which contains information about enrollment and services for ABD clients. In addition, **a** number of resources are located within the State which will be used to reach clients. The Authority will develop programs with advocacy groups for children, the disabled and the elderly, will provide client information through a statewide toll-free resource and information line for children with special health care needs (OASIS), and will collaborate with programs conducted by other State agencies, such **as** the ElderCare program located within the

Oklahoma State Department of Health and the Children with Special Health Care Needs program located within the Oklahoma Department of Human Services.

The Medical Director will be responsible for coordination of development of **an** enhanced benefits packages which reflect the unique needs of these populations. The State will collaborate in the development of these packages with providers familiar with special needs individuals.

2. PROCEDURES FOR DETERMINING ADEQUACY OF MANAGED CARE PROVIDER CAPACITY BY COUNTY

Introduction

This section of the operational protocol describes the State's methods for ensuring adequate provider capacity exists in MCOs and partially-capitated counties before managed care enrollment is started. The responsibilities of MCOs and PCCM providers with respect to offering and maintaining accessible services also are outlined. The section further discusses the provider capacity information that the State will make available to HCFA under the demonstration. It concludes by describing the State's activities with respect to access problems among Oklahoma's Title XIX-eligible homeless population.

Overall Capacity Assessment

Prior to beginning implementation of managed care in either MCO or PCCM counties/regions, the Managed Care Division of the Health Care Authority will conduct a thorough resource assessment to document the numbers and locations of hospitals, primary care providers, specialists, pharmacies, and alternative access points such as rural health clinics, health departments, FQHCs, tribal and IHS facilities, school based clinics, and mobile clinics. This preliminary evaluation will be used to determine whether a particular county or multi-county region has sufficient provider capacity to justify mandatory managed care enrollment. (as an example, Attachment **5** presents a portion of the resource assessment findings for the tri-county pilot area described in section 1).

Data for the resource assessment will be obtained primarily from the Authority's own Division of Health Care Information, which conducts an annual State-wide survey of providers, to quantify the number and type operating in each county. This baseline data will be used to determine the ratio of PCPs to clients, geographic proximity of PCPs to each other, as well as to clients, hospital utilization patterns, availability of other health professionals or facilities, alternative access points and lists of providers who have not participated in the fee-for-service program but who may wish to participate in a managed care delivery system.

The resource assessment also will take into consideration the number and geographic distribution of ***SoonerCare*** members who would be affected **by** this demonstration, as well **as** the currently existing community utilization patterns, referral patterns, and transportation issues. This information will be used to predict the impact of managed care on individual communities, counties, and multi-county regions.

If, based on an assessment, it is determined that:

- Inadequate provider capacity and/or resources exist to support any managed care system, or
- Inadequate provider capacity and/or resources exist to support a managed system capable of serving the entire county population of the county or region, or
- The accessibility to services or health status of participating individuals would suffer,

the State will exempt that county or region in its entirety from the managed care program and will keep all Medicaid beneficiaries in the fee-for-service program until such time as there are adequate resources to support a managed care system. This determination will be made on a county-by-county basis and may apply to groups of counties, (regions), but will not, in any instance be applied to a partial-county area due to the confusion any such split would create for members, providers and eligibility workers. The State currently is in the process of finalizing its assessment of all counties not included in the 1915(b) program and will make decisions about inclusion/exclusion of counties for the 1115(a) program before the end of the year.

Once it is determined that an area can support managed care, the State has defined detailed access standards for its fully-capitated (urban health plan/Rural Partner) service areas and its partially-capitated service areas. These standards are described below.

Urban Health Plan/Rural Partner Areas

Capacity

As a condition of RFPs issued under the State's 1915(b) waiver, responding MCOs were required to submit, both in hard copy form and on computer diskette, a detailed roster of their provider networks. The diskette was provided to MCOs by the State and included spreadsheet templates for reporting provider network information. (Attachment ***6*** contains a copy of the spreadsheets and provider maps for primary care providers in Oklahoma City).

For the next proposal submission, in addition to information required to be submitted under the 1915(b) program, all MCOs will be required to use the *GEO **Access*** computer program to map their provider networks and submit in hard copy form and on diskette **,** maps for each of the following groups:

- PCPs-general practitioners, family practitioners, pediatricians, and internists
- Obstetricians/gynecologists

- Other specialist physicians
- Mental health providers-private providers, community mental health centers, inpatient facilities

  Pharmacies

  Dentists-general and pediatric

  Vision providers-optometrists and ophthalmologists
- Hospitals
- IHS or tribal facilities, rural health clinics, FQHCs

After receiving the provider network information on diskette, the State will merge the MCO provider network maps with a database containing the geographic location of AFDC and ABD Medicaid beneficiaries within the MCO's proposed catchment area and determine whether or not the MCO has adequate numbers and appropriate distribution of providers within its network to meet the provider-to-member ratio and travel time standards specified in the RFP (these standards are discussed below).

Within their proposals, MCOs also will be required to provide information on the capacity of their primary care providers, to ensure these providers are able and willing to serve whatever enrollment the plan has proposed to accept. MCOs will be required to document individual and total primary care physician capacity on the same spreadsheets used to report the names and locations of their PCPs. On the spreadsheets, the MCOs will be required to show for each physician:

- The total number of patients the PCP has in his/her current practice including non-***Soonercare*** members
- The maximum number of ***SoonerCare*** patients the PCP is willing to accept
- The number of slots reserved for existing patients
- The number of slots open to new patients

In addition to evaluating the adequacy of individual health plan networks, the Authority also will examine total provider capacity across plans, by documenting which and how many network PCPs are included in multiple plans and if the PCP is also contracting with the State to serve rural patients as a PCCM (this dual PCP/PCCM option is described below). This information will be used to make adjustments, if appropriate, to the estimated plan capacity numbers submitted by MCOs in their proposals.

MCOs which are u able to demonstrate adequate provider capacity will not awarded contracts for *SoonerCare* unless they can present a reasonable plan to expand their networks. In this situation, a provisional contract may be signed, and the State will initially cap the number or geographic location of individuals the MCO can enroll and will not allow the MCO to have additional members until signed contracts with additional providers are in place and the MCO has passed a subsequent "readiness review" to be performed by the State.

Finally, as part of their proposals, MCOs will be required to describe their system for tracking the number of members enrolled with each PCP. In their contracts, MCOs then will be required to implement and maintain the described system and to ensure that PCPs who have reached capacity will not receive additional members, either through auto-assignment or by member selection.

Access Standards

In addition to meeting the conditions outlined above for provider networks, MCOs desiring to participate in the urban *SoonerCare* program must meet very specific requirements with respect to service accessibility. Specifically, MCOs must:

- Provide coverage twenty four hours per day, seven days per week.

- Make treatment for urgent medical or mental health problems available within twenty four hours. MCOs must also make treatment for non-emergent medical or mental health problems available within three weeks, excluding appointments for routine physical exams or regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits to occur less frequently than once every three weeks.

- Operate a twenty-four hour, seven day per week, toll-free telephone line for members seeking advice or assistance in obtaining services and instructions regarding how to obtain services after business hours and on weekends.

- Offer every member the opportunity to select a PCP located within a specified distance of the member's residence. For the Oklahoma City and Tulsa catchment areas, this distance is defined as a five mile radius around the member's residence. For the Comanche County catchment area this distance is specified as a twenty-five mile radius, or within forty five minutes driving time of the member's residence, whichever is less. As additional areas of the State are brought into managed care, the standard will be established based upon the usual and customary standard which is appropriate in the region but will not under any circumstances exceed the 45 mile/45 minute limit specified in Oklahoma's waiver approval terms and conditions.

- Include in the MCO network an adequate number of hospitals in the appropriate geographic distribution such that transport time for any member to the nearest hospital does not exceed 30 miles or 30 minutes driving time. As future rural areas

are brought into managed care, the State will consider the usual and customary standards for the community and will set this requirement accordingly.

- Offer every member the use of a network pharmacy within a seven-mile radius of the member's residence, or provide alternative methods for delivering pharmacy services to members, such as home delivery. MCOs must also contract with twenty-four hour pharmacies and must ensure that there is at least one such pharmacy within 40 minutes driving time from the member's residence. All MCO pharmacy providers must provide appropriate pharmacy counseling to MCO members to the extent required by OBRA '90.

- Contract with at least one general dentist for every 2,000 members and with at least one pediatric dentist for every 10,000 members or fraction thereof, under the age of 21. Appointment time cannot exceed three weeks for regular appointments and **48** hours for urgent care.

- Ensure that no more than 1,750 ***SoonerCare*** members per plan choose or are assigned to any single PCP. If the PCP practices in conjunction with nurse practitioners, physician assistants or medical residents, an additional 875 members may be assigned to the provider for each nurse practitioner, physician assistant, or medical resident affiliated with the PCP. PCPs in MCO networks who practice on the border of MCO/partial capitation service areas and who wish to serve **as** PCCMs for rural ***Soonercare*** members may accept up to 250 rural patients, subject to the distance and time standards for the rural model. This will not affect the number of urban members which they can serve.

- Contract with specialists so that members have access to care in-network for at least the following specialties: allergy, anesthesiology, cardiology, chiropractic, dermatology, endocrinology, gastroenterology, general surgery, hematology/oncology, nephrology, neurology, neurosurgery, obstetrics/gynecology, ophthalmology, optometry, orthopedic surgery, otolaryngology, pathology, physiatry, psychiatry, psychology, podiatry, pulmonology, radiology, rheumatology, urology, vascular surgery.

- Accept all patients who select or are auto-assigned to the MCO and not seek to disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin or type of illness or condition, except when that illness or condition can be treated better by another provider type and the State approves the disenrollment.

Although MCOs are not required to include school-based clinics in their networks for purposes of performing EPSDT screens, the State believes these clinics **may** add valuable primary care capacity and better enable MCOs to comply with outreach requirements and EPSDT periodicity schedules. In calculating the capacity of an MCO network during the evaluation of its proposal, the State gives special consideration to these contracts.

School-based clinics also supplement MCO networks by serving as "safety-net" providers. When it is determined by the school-based clinic that a child enrolled in managed care needs an EPSDT screen the clinic must contact the PCP to arrange an appointment. If one cannot be arranged within 10 days, the clinic is encouraged to provide the screen and bill the State fee-for-service (the State then deducts the cost of the screen from the health plan's next capitation payment, as discussed in the payment section of this protocol).

Rural Partial Capitation Service Areas

Capacity

As noted earlier in this section, the State will evaluate the resources within each county and/or region prior to implementing any managed care system. If it is determined that an area cannot support any managed care model, the area will remain in fee-for-service and will be re-evaluated on a yearly basis. If and when it is found to have sufficient resources to support managed care, any such area will be brought into managed care using a process similar to the one planned and described for the tri-county PCCM pilot project (see section 1).

Although the State intends eventually to implement several rural models or variations, initially all rural areas will operate under the PCCM model. Under this model, the primary care provider is capitated for outpatient office visits, limited laboratory and radiology services that would normally be associated with an office visit, and case management. This sub-capitated model does not put the primary care provider at great financial risk, but allows both the provider and ***Soonercare*** member to develop an understanding of the way managed care systems work. In many cases the implementation of this system will be both the provider's and member's first exposure to managed care. In addition, the capitation mechanism under this model provides incentives to the primary care provider to reduce inappropriate utilization of services included in the capitated rate.

The State has not defined an absolute number of providers in each rural county/region who would have to agree to participate before the ***Soonercare*** program would be implemented. Instead, the State has developed a contract that will specify the service accessibility, capacity and coverage standards that must be met by participating providers and will seek to contract with all providers who wish to participate, meet the credentialling requirements, and can demonstrate the ability to meet the specified standards.

Physicians eligible to serve as PCCMs for the AFDC population are defined as general practitioners, family practitioners, general pediatricians, and general internists. However, the State will consider requests from other types of providers to serve as PCCMs when they can document that they have been providing primary care services for this population and when it is necessary to include them to provide access. When the Aged,

Bli d, and Disabled populations are brought into the program in rural areas in late 1996, the State will permit sub-specialists to serve as primary care providers in order to ensure ready access to treatment for chronic medical conditions, as well as to promote continuity of care. The process for including sub-specialists as PCPs is described elsewhere in the protocol.

As noted above, the State has established a member-to-PCP ratio of 1,750-to-1 in its MCO service areas. The State also will permit PCPs in MCO networks to serve as PCCMs for up to 250 rural *SoonerCare* members. For physicians serving exclusively as rural PCCMs, the State will seek to cap the number of members per physician at 1,750, but reserves the right to increase this number in underserved areas to 2,500 to one, as long as this higher cap is in conformance with usual and customary standards for the community.

The State will also increase access in rural areas by allowing PCCMs to expand their capacity if they practice in conjunction with physician assistants or with nurse practitioners. PCCMs will be eligible to serve an additional 875 patients for each physician assistant or nurse practitioner affiliated with which he or she practices.

If a physician/PCCM practices at multiple sites, the capacity at each site will be determined based on the number of hours per week the physician holds office hours, not to exceed 1 FTE, and the number of physician assistants or nurse practitioners in practice at each site. The PCCM will be given alternate provider numbers for his or her different practice sites so that the State can track enrollment and capacity on a per site basis.

In areas where a severe shortage of physicians exists, the State also will allow nurse practitioners to serve as PCPs for a maximum number of 875 patients. In such cases, the Nurse practitioners will be required to practice in collaboration with licensed primary care physicians who are Medicaid providers and will be required to provide formal documentation of this arrangement. They will also be required to have immediate consultation and referral mechanisms with their primary care physician partner.

Finally, in the "border" areas of Oklahoma, where cross-state utilization patterns have developed because of limited provider capacity on the Oklahoma side of the border, the State may contract with out-of-state providers for PCCM services. Out-of-state PCCMs will be required to comply with all of the access standards imposed on Oklahoma physicians and the State will strongly encourage these providers to use Oklahoma specialists and hospitals when available.

The Managed Care Division in conjunction with the Provider Enrollment Division will be responsible for making out-of-state providers aware of the changes taking place in Oklahoma's program. On July 7,1995, a letter was sent to all providers, including those located out-of-state, explaining the envisioned program changes (subject to ultimate waiver approval). The Area Health Education Center (AHEC) in Ft. Smith, Arkansas has been contacted and will assist with the notification of Arkansas providers. The

Managed Care Division is in the process of identifying other agencies or organizations which could assist with this process along Oklahoma's northern border with Kansas and southern border with Texas.

Access Standards

As in the MCO service areas, the State has defined specific access standards for PCCMs. Specifically, they must:

- Provide coverage twenty-four hours per day, seven days per week, either directly or through coverage arrangements made with other providers, clinics, and/or local hospitals. Information about after hours coverage must be included **as** part of the credentialling information in the PCCM contract.

- Make treatment for urgent medical problems available within twenty four hours. PCCMs must also make treatment for non-emergent medical problems available within three weeks excluding appointments for routine physical exams or regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits to occur less frequently than once every three weeks.

  Accept all members who select or are auto-assigned and not seek to disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin or type of illness or condition, except when that illness or condition can be treated better by another provider type and the State approves the disenrollment.

For its part, the State in rural areas will:

- Ensure that there is an adequate number of primary care providers with sufficient capacity to provide primary care services to all eligible beneficiaries in the county/region.

- Offer every enrollee the opportunity to select a PCCM located within 30 minutes driving time or 30 miles or the usual and customary community standard **as** determined by the State. For example, in some remote areas in the panhandle of the State, it may be necessary to establish travel times/distances up to 45 miles and 45 minutes.

- Track the number of members enrolled with each PCCM and guarantee that PCCMs who have reached capacity will not receive additional members either through auto-assignment or by member selection. In the event that a member chooses a PCCM whose practice is full or closed, the State may assign a replacement PCCM to the member. However, the member will be allowed to change the assignment within 30 days of notification if he or she is dissatisfied. When a PCCM reaches capacity or is

no longer accepting new patients, this information will be reflected in the PCCM provider directory prepared by the State.

- Provide adequate access to hospital services such that the transport time to the nearest hospital does not exceed 30 miles or 30 minutes driving time or the usual and customary community standard for this service.

Assurance of Information Availability

At any time during this demonstration project, the State will make available to HCFA the addresses of eligibles and providers within 90 days of such request . This information will be available for both MCO and partial capitation areas and in both hard copy and computer diskette form.

Within 90 days after the award of contracts (annually) to MCOs, the State will provide HCFA with detailed rosters of the MCO provider networks, including both primary care providers and specialist providers. Additionally, in the event of a change to any MCO provider network which could significantly increase or decrease access and/or quality of care, the State will transmit this information to HCFA within 30 days.

The State will provide HCFA with a list of rural PCCM and specialist providers on an annual basis. This information will be provided within 90 days of the return due date for PCCM contracts.

Homeless Population

In both the MCO and partial capitation areas of the State, AFDC and ABD beneficiaries who are homeless will have access to managed care through the *SoonerCare* program. Currently, homeless recipients are allowed to list addresses of homeless shelters or churches as permanent addresses to establish Medicaid eligibility and access medical care. In its existing MCO service areas, State has required plans to contract with providers who know and understand the needs of this population. Many of these providers are considered to be "traditional providers" under the criteria established by the State and thus were given special contracting status as described elsewhere in the protocol.

In the rural areas or the State, persons who are homeless will be given the opportunity to select a PCCM or will be auto-assigned. Recognizing that many members of this group have multiple health risks, including HIV, the State is establishing a stop-loss provision for its PCCM providers. This provision would lessen the financial risk to providers who may serve large numbers of high-risk patients, for example, if a PCCM is the only provider in the Community or has a particular commitment to serving special populations.

In order to strengthen outreach efforts to the homeless, the Client Enrollment Section of the Managed Care Division already has contacted by telephone or met with several community service organizations such as the Salvation Army, Red Cross, Jesus House, Families First, Primary Care Association, Legal Aid, Community Council and various local Church groups. Additionally, in the Oklahoma City Area, Mary Mahoney, an FQHC which has contracted with all of the participating MCOs, has a satellite facility specifically to care for the homeless population. Education materials explaining the *SoonerCare* program have been distributed to all of these agencies and they have agreed in turn to *make* them available to homeless clients.